The Commonwealth of Massachusetts

Executive Office of Health and Human Services
Department of Mental Health
Elizabeth Childs, MD, Commissioner

FISCAL YEARS 2005-2007
STATE MENTAL HEALTH PLAN

FY'07 Submission

DRAFT

September 2006

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2005 - 2007 STATE MENTAL HEALTH PLAN

"The Department of Mental Health, as the State Mental Health Authority, assures and provides access to services and supports to meet the mental health needs of individuals of all ages, enabling them to live, work and participate in their communities. The Department establishes standards to ensure effective and culturally competent care to promote recovery. The Department sets policy, promotes self-determination, protects human rights, and supports mental health training and research. This critical mission is accomplished by working in partnership with other state agencies, individuals, families, providers and communities."

FEDERAL FUNDING AGREEMENTS, CERTIFICATIONS, ASSURANCES AND REQUIREMENTS

FFY'07 MAINTENANCE OF EFFORT & CHILDREN'S SET-ASIDE

EXECUTIVE SUMMARY

As reported last year (SFY 2005), the Department of Mental Health (DMH) completed a three-phase process to develop a comprehensive Strategic Plan. The overarching goals were to:

- transform the mental health system;
- incorporate equity, individual, family and recovery-oriented values into the system redesign; and
- improve overall quality.

The three major initiatives based on the plan that DMH Commissioner Elizabeth Childs, M.D. chose to focus on in SFY 2006 were: planning for the implementation of a unified public behavioral health system; community expansion in conjunction with planning for the building of a new DMH inpatient facility; and developing an overarching quality structure for the Department. DMH has made progress on all three initiatives during the year and is set to further these projects in SFY'07.

The initial focus for unifying the public behavioral health system, and the leading activity that we expect will transform the mental health care delivery system in Massachusetts, is to further coordinate the care provided by the behavioral health systems supported by DMH and MassHealth (Medicaid, formerly Division of Medical Assistance). This is essential since DMH's operational responsibility, as the SMHA, was expanded when the Executive Office of Health and Human Services placed the MassHealth Behavioral Health programs under the supervision of DMH. To accomplish this goal, DMH sponsored multiple group meetings across the Commonwealth, over a period of several months during SFY'06, to address planning for adult services, planning for child and adolescent services, and fiscal and administrative issues. The service planning groups were composed primarily of DMH staff at various levels of the organization but also included adult consumers, youth, and family members of adults and youth. This was the first step of an ongoing process that is expected to continue through the calendar year. In the context of unifying the two systems of publicly-funded mental health care, which, ideally, also will integrate with private insurance, key areas of focus include: identifying a single point of clinical accountability for each person; designing a system that is consumer and family-directed and recovery-oriented; increasing information about and access to mental health services; and reducing disparities for ethnic and cultural minorities. DMH also contracted with consumer-run Consumer Quality Initiatives, Inc. to conduct focus groups on specific topics with consumers of all ages and family members to obtain input on service needs.

Recommendations resulting from the initial planning process were incorporated into a Request for Responses (RFR) to assist DMH as it plans to procure a redesigned system that can sustain the Department's commitment to consumer/family-directed and recovery-focused values. The RFR was issued in Spring 2006. The respondents, a group of nationally known experts, came on board at the end of June to support the redesign process, both programmatically and fiscally. SFY'07 will begin with a series of forums for providers across the state. The recommendations emanating from the earlier forums will be shared and providers will be asked to contribute their thoughts regarding strengths of the current system, suggest areas for change and provide feedback to DMH about the effect of proposed changes on their service delivery systems. The procurement process is

expected to be accomplished in phases, beginning in calendar year 2007. Procurement of the child and adolescent system may occur later due to the "Rosie D." lawsuit. The plaintiffs (legal advocates) successfully challenged the adequacy of Medicaid's provision of EPSDT entitlements for children with serious emotional disturbance. Although DMH was not named as a defendant, the outcome of the lawsuit may affect DMH as it is expected that Medicaid will assume more responsibility for services currently provided through DMH funding.

The second initiative is community expansion/hospital planning. This combines the twin goals of placing discharge-ready adult patients into the community over an extended period of time, with proper support services, and consolidating two of the oldest hospitals and replacing them with one new state-of-the-art facility in the central part of the state. Of *268* patients originally identified as most ready for discharge three years ago, *169* were discharged and placed in the community as of June 30, 2005 and *62* more were discharged and placed in the community as of June 30, 2006, for a total of *231* placements. The legislature provided funding to support the existing placements (pre-SFY'06) and $1.885 million for the additional placements in SFY'06. In addition, a facility commission created by the legislature completed its study and released design and site recommendations, and cost estimates, for the new hospital, to be located on the grounds of the current Worcester State Hospital, the oldest public "asylum" in the United States (1833). Many DMH staff as well as consumers, family members and other interested parties participated in the design discussions about the new hospital. The legislature made the final determination as to location and will make the final determination as to spending for the new facility when it recommends and passes new bonding authorization.

The third initiative, developing an overarching quality structure for DMH, has been launched. A draft quality improvement plan, including a proposed organizational structure, is being reviewed by senior staff, and an important position – Director of Quality Improvement – has been filled. A best practice survey was conducted, including interviews with four states. In conjunction with implementation of the Department's Data Infrastructure Grant, the first ever statewide consumer satisfaction survey is ready to be conducted. The first year's effort will survey adult and adolescent consumers as well as family members of younger children about their experiences in 24-hour residential programs, education and employment programs, case management and inpatient services and the ways in which these services have affected their lives. It also will give DMH an opportunity to identify where improvements are needed, provide a baseline for future surveys and analysis and contribute to procurement planning.

Other Highlights

In SFY'05, a project was initiated to audit all of the Department's PACT teams. The audit aims to assess each team's strengths, weaknesses and fidelity to the established model. During SFY'05, four of the 13 teams were audited; the remaining eight teams were audited in SFY'06. The audits were conducted by a multidisciplinary team of DMH staff, and included a physician, Site Director, Quality Improvement and Social Work staff. Findings will help DMH to ensure consistency and high quality care.

Following the audits, each team received a copy of its evaluation and recommendations. Each team responded with a corrective action plan, which is being

monitored. The results of the audit were reviewed statewide to develop training which was provided to the teams during SFY'06. The training focused on vocational/job services and development within the PACT model, treatment planning and interventions consistent with the PACT model, and medical records as a reflection of treatment in the PACT model. Training in recovery and client empowerment was provided by Dr. Pat Deegan, and support and training were provided to the Peer Specialists on the PACT teams by M*Power.

Opportunities for employment are seen as a principal force in promoting recovery. The SEE program (Services for Employment and Education) is a flexible, community-based service that provides access to an array of employment, skill training and educational opportunities for DMH clients. A range of employment services, including transitional, supported and independent employment also is provided in clubhouses. DMH provides the majority of funding for clubhouses in the state, and the clubhouses abide by standards that define their mission, membership and programs. Although most clubhouse members are referred by DMH and meet DMH eligibility criteria, members are not required to formally apply for DMH client eligibility to participate in the clubhouse programs. DMH is continuing to work with the SEE programs and clubhouses to obtain reliable data to measure unduplicated employment rates for SEE clients and clubhouse members. There is also a desire to develop a mechanism to track employment tenure, in addition to job placement. Members of the Planning Council have expressed great interest in pursuing these goals and are in the process of petitioning the Council to set up a permanent subcommittee on employment. In SFY'06, *56.02* ***%*** of SEE clients and ***XX%*** of clubhouse members were successfully employed.

As the State Mental Health Authority, DMH has statutory responsibility to *take cognizance of all matters affecting the mental health of the citizens of the Commonwealth.* To fulfill this obligation, DMH has an organizational structure in place to provide emergency and disaster services, including crisis counseling to the general public during times of President or Governor-declared states of emergency, or other local, regional or statewide catastrophic events. This is carried out in coordination with other public and private organizations that provide time and resources on a volunteer basis, such as the American Red Cross, Department of Public Health (DPH) and private mental health professional groups. DMH will receive $214,000 in HRSA funding through DPH for Disaster Management Training in SFY'07. A training curriculum was designed and four training sessions were held in SFY'06 (in addition to the five that were held in SFY'05). In SFY'06, *270* people were trained, a substantial number of whom were licensed clinicians, and *249* of the trainees signed up to be state behavioral health disaster responder volunteers (crisis counselors). The training program will continue in SFY'07, with the first session scheduled for July 25th and July 26th.

In SFY'05, as one of eight states selected by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) for its anti-stigma Elimination of Barriers Initiative (EBI), Massachusetts DMH, in partnership with the Massachusetts Association for Mental Health, provided training for teachers, special services staff and administrators in four high schools. In SFY'06, DMH received funding from EBI to support a project targeted to elders. "Eliminating Barriers to Mental Health Treatment: A Guide for Massachusetts Elders, Families and Caregivers" was published in late spring of SFY'06 in partnership with the Massachusetts Association for Older Americans (MAOA)

and distribution has begun. The four annual conferences sponsored by MAOA provide one important vehicle for disseminating the Guide and spreading the anti-stigma message. This time-limited project complements a collaborative effort by DMH, the Executive Office of Elder Affairs and the MassAging and Mental Health Coalition to develop an Elder Mental Health Plan, one of the longer-term goals in the Department's Strategic Plan. In addition, this group petitioned the State Mental Health Planning Council for adoption as a sub-committee of the Council, which was granted.

DMH is an active participant, along with the UMass Center for Health Policy and Research, and consumer-led organizations such as M*Power and Consumer Quality Initiatives, on a three-year grant from SAMHSA that has led to the development of the Transformation Center. The Center's goal is to increase the capacity of consumer-led services, including expanded peer support and advocacy opportunities for older adolescents and adults, throughout the behavioral health system. The Center is guided by the Transformation Committee ("Transcom"), a diverse group of stakeholders that sets priorities, facilitates a vital exchange of ideas and provides leadership as DMH continues a transformative process leading to a more consumer and family-centered system.

DMH continues to provide technical assistance to its licensee, contracted and state-operated child and adolescent hospitals and adult inpatient units, and intensive residential treatment programs to prevent and reduce the use of seclusion and restraint in those facilities. Results of this work have been presented nationally and internationally at conferences and training sessions. DMH is committed to the reduction and eventual elimination of seclusion and restraint throughout its entire service system. In SFY'05, DMH received a three-year grant from SAMHSA to focus on the adult state hospitals in the DMH system, and is currently in its second grant year. In SFY'06, DMH promulgated state-of-the-art restraint and seclusion prevention-oriented regulations. DMH provided two 2-day national trainings developed by NTAC entitled "Creating Coercion-Free and Violence-Free Mental Health Treatment Environments." This was offered to all child-serving programs and all adult, child and adolescent psychiatric inpatient units licensed by DMH in an effort to support the entire inpatient psychiatric service system across the Commonwealth in implementing the new regulations.

Under the leadership of the DMH Office of Multicultural Affairs (OMCA), the second, three-year Cultural Competence Action Plan (CCAP) was developed and approved in SFY'05. The plan includes goals and objectives in the areas of Community Partnerships, Leadership, Training and Education, Human Resources, Services, Information, and Data and Research. In SFY'06, each of the six DMH Areas prepared and submitted its individual Area Action Plan. Each Action Plan, developed by the Area's multicultural diversity committee, was formulated by using the CCAP as a roadmap. The plans were reviewed and approved by the DMH Cultural Competence Action Team and the OMCA Director.

The world of children's services has continued to receive a great deal of attention, both within and outside of DMH. The ongoing activities related to "Rosie D." as well as the implementation of the new child welfare procurement, have involved DMH staff in numerous interagency discussions to assure system coordination. The Executive Office of Health and Human Services (EOHHS) Mental Health Commission, whose role formally ended in June 2005, has continued to meet as an advisory body to the DMH Commissioner to oversee implementation of the Commission's priorities. Work has

focused on insurance/Medicaid reimbursement for mental health screening, promotion of mental health insurance parity through data collection and work on defining intermediate level care, and advocacy for early childhood mental health services. And lastly, $3 million appropriated to DMH in the SFY'06 budget to fund services for youth transitioning from the child/adolescent to the adult service system, was used to promote youth development, develop a strong youth voice, provide services for children with serious emotional disturbance who were aging out of special education, child welfare and juvenile justice, and funded housing, job mentoring, local leadership councils and individualized supports. The SFY'07 budget contains additional funds targeted to this population.

Research is one of the statutory pillars of DMH and the Department actively supports a broad research agenda. DMH currently funds two research centers: Harvard Medical School (Clinical Neuroscience Research) and University of Massachusetts Medical School (Systemic and Psychosocial Research), and provides a small stipend to Boston University Medical School for Multicultural Research. In SFY'07, DMH will work to expand the accessibility of research and the translation of research results into practice. These efforts are related directly to the recommendations of the President's New Freedom Commission Report and the Institute of Medicine report "Crossing the Quality Chasm."

Contracts for university-based research to support the Department's transformation will be re-bid in SFY'07. These contracts will focus research on such topics as effectiveness and efficiency of service delivery models, rehabilitation and recovery, reducing racial and ethnic disparities in access to care, forensic services, stakeholder satisfaction, neurobiological studies, efficacy of psychopharmacological treatments, genetics and the impact of environmental and biological stressors, and the effects of lifestyle choices. The integration of these lines of research into the DMH service environment is expected to maintain Massachusetts' leadership role in the development and provision of services for vulnerable populations.

Continuing Initiatives

The Mental Health Information System has been implemented in all DMH Areas and includes all financial and administrative data and an electronic medical record for the hospitals, and a care management tracking system for community clients. Data are collected, stored and retrieved from the Data Warehouse and a system of queries is being continuously improved to ensure consistency in data reporting. The Data Infrastructure Grant from SAMHSA has provided DMH with an additional resource for data analysis and support. The DMH Internet website at www.mass.gov/dmh, part of a comprehensive website for all EOHHS agencies, receives requests from internal and external sources and responded to more than *637* requests for help or information in SFY'06. The Internet website complements the Intranet site that DMH has operated for its own employees for seven years. DMH also operates a consumer-run information and referral toll-free line. This line received *1,072* calls in SFY'06: *313* from consumers, *279* from family members, *320* from providers, and *160* from the general public.

Interagency service delivery projects focused on youth continue to flourish. These include three programs specifically targeted to prevention of out-of-home

placement: the state-wide DMH/DSS Collaborative Assessment Program for children not previously involved with state agencies; the Mental Health Service Program for Youth, a five-town initiative for certain MassHealth recipients enrolled in the Neighborhood Health Plan; and the Coordinated Family-Focused Care Initiative administered through the Massachusetts Behavioral Health Partnership (MassHealth's behavioral health vendor). The newly funded interagency Central Massachusetts Communities of Care, a federal service demonstration project funded by the state child serving agencies and the federal Center for Mental Health Services, is focused on reducing juvenile detention and CHINS (Children In Need of Services) placements. Also, the legislature has renewed funding for the Massachusetts Child Psychiatry Access Project, which provides primary care practitioners with access to child psychiatrists for consultation and referral. In all cases, the overarching goal is to provide high quality, culturally competent systems of community-based care.

Since FY'02, state appropriations have supported the Massachusetts Suicide Prevention Program, expanding many prevention efforts begun in prior years. Priority activities center on community education, implementation of the Massachusetts State Plan for Suicide Prevention, raising awareness of the preventable nature of suicide and survivor services advocacy. The program addresses issues of suicide prevention across the lifespan and is guided in its allocation of resources by DPH line-item budget language, by the Massachusetts Strategic Plan for Suicide Prevention and by DMH and the Massachusetts Coalition for Suicide Prevention recommendations. The program is operated by DPH in full collaboration with DMH. DMH is represented on the Executive Steering Committee and on the Youth Development Committee of the Massachusetts Coalition for Suicide Prevention and, as the SMHA, plays an active pivotal role in recommendations relative to spending, strategic planning, and implementing the goals of the State Plan for Suicide Prevention.

The Department continues a host of other activities, including various collaborative efforts to promote interagency cooperation and systems integration for shared populations. These include a focus on the problem of chronic homelessness, developing and enhancing behavioral health services to individuals in the juvenile and criminal justice systems and supporting the special needs of parents with mental illness and their children.

The State Mental Health Plan

DMH submitted a three-year (2005-2007) State Mental Health Plan as part of its Fiscal Year 2005 Block Grant application. Last September (2005), DMH submitted an update to that Plan, which included several modifications of performance measures. In March 2006, two additional changes were made as a result of a decrease in the federal allocation to Massachusetts. This year's submission includes these earlier changes and makes a few additional ones. All changes to the original three-year Plan are so noted and indexed to the page in the original Plan. The plan continues to follow the state's fiscal year.

DMH has tried to reflect the values, goals and objectives of the President's New Freedom Commission Report in the development of its Comprehensive Mental Health Plan. This Plan also includes objectives and performance targets developed for the (state) Executive Office of Health and Human Services and from the Commissioner's articulated

goals for this year and beyond. Goals, objectives and performance targets for the Block Grant State Mental Health Plan were drawn from the more comprehensive plan, based on the availability of reliable data sources. Some of the items DMH has chosen to measure are: case management, residential services, employment, access, level of functioning, client satisfaction, community tenure, smoking reduction, and options for people with mental illness who are homeless. Additional process-oriented indicators are presented as well.

The Department's Mental Health Information System (MHIS) is now fully functioning in all of its domains and in all DMH Areas, although system limitations occasionally necessitate the use of alternatively maintained databases to obtain accurate, up to date information. Most of the data in this report have been derived from MHIS, as are the URS Tables that will be included in the Implementation Report that is due to CMHS in December.

THE STATE MENTAL HEALTH PLANNING COUNCIL

The State Mental Health Planning Council is a standing committee of the Statewide Advisory Council (SAC) to the Massachusetts Department of Mental Health. The SAC, established by statute (MGL c.19, section 11) and regulation (104 CMR 26.04 [4]) consists of 15 individuals appointed by the Secretary of the Executive Office of Health and Human Services to "advise the commissioner on policy, program development and the priorities of need in the Commonwealth for comprehensive programs in mental health." The Council does not have its own set of bylaws. All members of the Planning Council are nominated and appointed by SAC and include consumers, family members, legal and program advocates, providers, other state agencies, mental health professionals and professional organizations, legislators and representation from state employee unions. Membership includes family members of adults and children and members of racial, cultural and linguistic minority groups. The Council has been successful in recruiting more representatives from various cultural and linguistic minority groups in the state via the Multicultural Advisory Council. The Department provides staff to the Planning Council.

Many members of the Planning Council also are involved in locally based participatory planning processes and with other advocacy groups. As issues arise, smaller groups function as subcommittees of the Council, with membership that includes individuals on the Planning Council as well as other interested persons. These issues include the mental health needs of elders, children and adolescents, and young adults. There is interest in exploring the development of a subcommittee on employment, based on feedback from a very successful employment-focused forum that was sponsored by the Council this year.

Elder Mental Health Issues: About 10 years ago, an Elder Mental Health subcommittee of the Council produced a set of recommendations and a written curriculum on "the unique mental health needs of the elderly." Training was provided to the field based on the curriculum. In addition, the subcommittee successfully lobbied DMH for funds to hold training conferences for professionals and advocates to improve and increase mental health services for elders. DMH has contracted with the Massachusetts Association for Older Americans every year since SFY'95 to run these conferences and will do so again in SFY'07. In SFY'05, a group of advocates from the MassAging and Mental Health Coalition, DMH staff and representatives from the Executive Office of Elder Affairs began to meet regularly to re-examine the former committee's recommendations and develop a state mental health plan for elders. This *Elder Mental Health Group* now functions as a subcommittee of the Council and two committee members have formally joined the Council. Sadly, the Council lost one of its premier "elder" advocates this year when long time member Ruth Robinson passed away.

Child/Adolescent Issues are tracked by the Professional Advisory Committee (PAC), which serves as a regular advisory group to the DMH Child/Adolescent division. The PAC reviews planning for children and adolescents and advocates with the administration and legislature on a broad range of issues related to children's mental health. A *Youth Development Committee* that was formed to address the particular needs of transitional age youth has become a working subcommittee of the Council.

The Planning Council reviews the State Plan, monitors its implementation and advocates regarding mental health system issues. It also meets to review and consider topics or programs of interest to Council members. It met on November 22, 2005 to review the 2005 Implementation Report, on April 26, 2006 for a program about all aspects of consumer employment and to hear from Commissioner Childs about implementation of the Department's Strategic Plan, on June 21, 2006 for a presentation on "transformation" activities and to provide input to the SFY'07 Plan, and finally on August 24, 2006 to review and approve the 2007 Block Grant application. Calls for action at the August 24th meeting by the Council included:

Notes from 8/24/06 meeting will be inserted here.

List of Planning Council Members (Table 1)

Name	Type of Membership	Agency or Organization	Address & Phone
Mark Belluardo-Crosby	Provider	SEE Coalition; Bay Cove Human Services	66 Canal Street Boston, MA 02114 Tel.# 617-788-1027
Ellen Boley	Consumer	MDDA, Alliance for the Mentally Ill of Mass, Inc.	1520 Ocean St. 2-34, Marshfield, MA 02050 Tel.# 781-500-9163
John Bove	Family Member – (Adult)	Alliance for the Mentally Ill of Mass, Inc.	15 Kenwood Drive, Plymouth, MA 02360 Tel.# 508-997-0475
Rep. F.D. Antonio Cabral	Legislature	Chairman, Joint Committee On Human Services & Elder Affairs	State House – Rm.# 22, Boston, MA 02133 Tel.# 617-722-2140
*Bernard J. Carey, Jr., Executive Director	Advocate (Housing); Family Member	Mass. Association for Mental Health	130 Bowdoin St. Boston, MA 02108 Tel.# 617-742-7452
Cornelius Curtiss Carter	Advocate	Multicultural Advisory Committee	130 Dartmouth St. # 1202 Boston, MA 02116 Tel.# 617-424-1918

Name	Type of Membership	Agency or Organization	Address & Phone
*Judi Chamberlin	Consumer	National Empowerment Center	67 Magnolia St., Arlington, MA 02474 Tel.# 781-777-1154
Valeria Chambers	Consumer	Consumers of Color Peer Networking Project - M*Power	70 St. Botolph St. #818 Boston, MA 02116 Tel. # 617-424-9665
John Chappell	State Agency	Mass. Rehabilitation Commission	27 Wormwood St., Boston, MA 02110 Tel. # 617-204-3620
Ted Chelmow	State Agency	Executive Office of Elder Affairs	One Ashburton Place, Boston, MA 02108 Tel.# 617-222-7420
Patricia Cone, Ph.D., J.D.	Criminal Justice	Administrative Office of the Trial Court – Juvenile Department	3 Center Plaza, #520 Boston, MA 02108 Tel.# 617-788-6550
Cheryl Cumings	Elder Advocate	Boston Partnership for Older Adults	99 Chauncy St. #602 Boston, MA 02111 Tel. #617-482-7778
Deborah Delman	Consumer	M*Power	98 Magazine St., Roxbury, MA 02119 Tel.# 617-442-4111
Jon Delman, Executive Director	Consumer	Consumer Quality Initiatives, Inc	132 Kemble St. Roxbury, MA 02119 Tel.# 617-427-0505
Colleen Doherty	State Agency/Employee Union	Dept. of Mental Health/ SEIU-Local 509	400 Talcott Avenue Watertown, MA 02472 Tel#., 617-924-8509
Peter Dulchinos	Family Member – (Adult) (Child Advocate)	Statewide Advisory Council	17 Spaulding Rd., Chelmsford, MA 01824 Tel.# 978-256-5256
Stan Eichner, Acting Executive Director	Advocate (Legal)	Disability Law Center	11 Beacon St., #925 Boston, MA 02108 Tel.#617-723-8455
Elena Eisman, Ed.D., Executive Director	Professional	Mass. Psychological Association	195 Worcester St.-#303, Wellesley, MA 02481 Tel.# 781-263-0080
Joseph Finn	Advocate (Homeless)	Mass. Housing & Shelter Alliance	5 Park St., Boston, MA 02108 Tel.# 617-367-6447 x14

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Tobias (Toby) Fisher, Executive Director	Advocate (Family Members)	Alliance for the Mentally Ill of Mass, Inc.	400 West Cummings Park - Suite #6650 Woburn, MA 01801 Tel.# 781-938-4048
Robert Fleischner	Advocate (Legal/Human Rights)	Center for Public Representation	22 Green St., Northampton, MA 01060 Tel.# 413-586-6024 x265
Sally Fogerty	State Agency	Department of Public Health	250 Washington Street Boston, MA 02108 Tel# 617-624-6090
Peter Foulkes	Consumer	Genesis Club	1050 Main St. #815 Worcester, MA 01603 Tel. # 508-797-9015
Susan Getman, LICSW	State Agency	Department Social Services	24 Farnsworth St., Boston, MA 02210 Tel. # 617-748-2258
Mary C. Gregorio, C.R.C., Director	Provider (Clubhouse/Rehab)	U.S. Psychosocial Rehab Assoc./Center House, Inc.	31 Bowker St., Boston, MA 02114 Tel.# 617-788-1002
Phil Hadley	Family Member - (Adult)	Alliance for the Mentally Ill of Mass., Inc.	400 West Cummings Park, #6650 Woburn, MA 01810 Tel. #781-938-4048
Marjorie Harvey	Advocate (Elders)	Statewide Advisory Committee	80 Park St. - #23, Brookline, MA 02446 Tel. # 617-735-9477
Anthony Jackson, M.D.	Professional	New England Council of Child/Adolescent Psychiatry	31 Woodlawn Ave., Needham, MA 02492 Tel. # 781-449-2512
Lisa Lambert	Family Member – (Child)	Parent/Professional Advocacy League/PAC	59 Temple Pl. - #664, Boston, MA 02111 Tel. # 617-542-7860 x203
Frank Laski, Executive Director	Advocate (Legal/ Human Rights)	Mental Health Legal Advisors Committee	399 Washington St., Boston, MA 02108 Tel.# 617-338-2345 x23

Name	Type of Membership	Agency or Organization	Address & Phone
Pat Lawrence	Family Member – (Adult)	Alliance for the Mentally Ill of Mass., Inc.	8 Elliot Rd. Lynnfield, MA 01940 Tel. # 781-334-5756
Nancy Blake Lewis, Executive Director	Family Member – (Adult) (Child Advocate)	Refuah	15 Hemlock Terrace, Randolph, MA 02368 Tel. # 781-961-2815
David McClosky	Provider (Homeless Mentally Ill)	Mass. Shelter Providers Association	701 Main St., Worcester, MA 01610 Tel.# 508-757-0103
Dennis McCrory, M.D.	Professional (Rehabilitation)	Friends of the Psychiatrically Disabled	6 Ridge Ave. Newton Ctr, MA 02459 Tel. # 617-471-9990
Jo Ann McGuirk	State Agency	Department of Housing & Community Development	One Cambridge St., #300 Boston, MA 02114 Tel. # 617-573-1301
Joan Mikula	State Agency	DMH - Children/ Adolescents	25 Staniford St., Boston, MA 02114 Tel.# 617-626-8086
Marcia Mittnacht	State Agency	Department of Education – Office of Special Educ. Planning & Policy Development	350 Main St., Malden, MA 02148 Tel. # 781-338-3388
Michael Norton	State Agency	DMH -Medicaid Behavioral Health Programs	25 Staniford St., Boston, MA 02114 Tel.# 617-626-8252
Tim O'Leary	Advocate (Housing, Anti-Stigma)	Mass. Association for Mental Health	130 Bowdoin St., Boston, MA 02108 Tel.# 617-742-7452
Wayne Perry	State Agency	Developmental Disabilities Council	1150 Hancock St. Quincy, MA 02169 Tel.# 617-770-7676 x104
Gailanne Reeh	Advocate (Children/ Elders)	Arbour Associates, Inc.	15 Court Sq., #1050, Boston, MA 02108 Tel.# 617-227-8829
Mary Roderick, MSW	Professional	Mass. Association of Social Workers	53 Hillside Ave., Bedford, MA 01730 Tel. # 617-484-0193

Name	Type of Membership	Agency or Organization	Address, Phone & Fax
Beverly Sheehan	Professional Organization	Mass. Psychiatric Society	40 Washington St. Wellesley, MA 02481 Tel.# 781-237-8100
Jessel-Paul Smith	Consumer	Mass. Consumer Satisfaction Team, Inc.	98 Magazine St., Roxbury, MA 02119 Tel.# 617-442-4111
Reva Stein	Advocate	Mass. Clubhouse Coalition	15 Vernon St. Waltham, MA 02453 Tel.# 781-788-8803
Miche'le Torres	Advocate	St. Francis House; Multicultural Advisory Committee	Essex Station PO Box 120499 Boston, MA 02112 Tel. #617-654-1206
Sen. Susan C. Tucker	Legislature	Chairwoman, Joint Comm. on Human Services & Elder Affairs	State House, Rm.416-A, Boston, MA 02133 Tel.# 617-722-1612
Sandra Vickery	Advocate (Elders)	Councils on Aging	P.O. Box 806 Monument Beach, MA 02553 Tel#508-759-0653
Chuck Weinstein, LMHC	Provider (Homeless Mentally Ill)	Tri-City Mental Health Center	173 Chelsea St.. Everett, MA 02149 Tel. # 781-388-6292
Donna Welles, Executive Director	Family Member – (Child)	Parent/Professional Advocacy League/PAC	59 Temple Pl., # 664 Boston, MA 02111 Tel.# 617-542-7858
Anne Whitman	Consumer	Cole Resource Center, McLean Hospital	4 Dana Place, Cambridge, MA 02138 Tel.# 617-855-3298
John D. Willett	Family Member – (Child)		14 Cottage St., Apt. C Pepperell, MA 01463 Tel.# 978-858-4462
Vacant	Family Member - (Child)		

* Co-Chair of Planning Council

Planning Council Composition by Type of Member (Table 1A)

Type of Membership	Number	% of Total Membership
TOTAL MEMBERSHIP		
Consumers/Survivors/Ex-patients (C/S/X)	8	15%
Family Members of Children with SED	3	6%
Family Members of Adults with SMI	6	12%
Vacancies (C/S/X & family members)	2	
Others (not state employees or providers)	19	37%
TOTAL C/S/X, Family Members & Others	36	
State Employees	12	23%
Providers	4	8%
Vacancies	0	
TOTAL State Employees & Providers	16	

Public Comments on State Plan

The State Mental Health Planning Council, a comprehensive, 52-member body comprising all of the stakeholders with an interest in mental health services in the Commonwealth, has been the primary reviewer of the State Mental Health Plan and Implementation Report for many years. However, in addition to the Plan's review by the Council, DMH now posts the Plan on its Internet website. This potentially expands the scope of input and review of the Plan to include interested members of DMH and the general public, other state agencies, legislative leaders, all of DMH's citizen advisory boards, legal advocates, provider groups, professional organizations, and consumer and family groups.

SEPTEMBER 2005 AMENDMENTS TO 2005-2007 PLAN

ADULT INDICATORS

Objective I/1 A: **Prepare for coordinating and delivering mental health services in the event and/or aftermath of a natural or man-made disaster (Page 52).**

Brief Name: *Disaster Management*

AMENDMENT: CHANGE YEAR 3 GOAL TO REFLECT EXPIRATION OF FEDERAL GRANT AND CONSEQUENT MOVE FROM DIRECT TRAINING TO TRAIN-THE-TRAINER MODEL.

Indicator: DMH collaborates with its community partners to foster resilience and preparedness, and increase stress management skills among the population before any untoward event.

Measure: The Commonwealth prepares for and responds to the mental health needs of its citizens in the event of a disaster.

Year 1: Develop an evidence-based, culturally competent and developmentally appropriate program to train licensed mental health professionals to respond appropriately and quickly in the event of a natural and/or man-made disaster; train 75 crisis counselors per quarter.

Year 2: Continue to train 75 crisis counselors per quarter; develop official credentialing criteria for crisis counselors and integrate their certification with certification criteria being developed by DPH for health care volunteers.

Year 3: Continue to train crisis counselors using a train-the-trainer model; identify trained DMH crisis counselors in each DMH Area to function as liaisons with regional DPH and Department of Homeland Security planning groups to ensure that behavioral health issues are included in all aspects of disaster planning and management.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/1. *Disaster Management*					
Value/Measure: Massachusetts prepares for and responds to the mental health needs of its citizens in the event of a disaster	DPH grant received; DMH role defined	Training curriculum designed; 75 clini-cians/Q trained	Training curriculum designed; 355 clini-cians trained	Credential process designed; 75 clini-cians/Q trained	DMH-DPH-DHS liaison created; clinicians trained

Data Source: DMH/DPH Grants Management

Background: While the primary mission of the Massachusetts Department of Mental Health is to provide services to citizens with long-term or serious mental illness, the Massachusetts statute governing DMH also requires it to *take cognizance of all matters affecting the mental health needs of the citizens of the Commonwealth.* Accordingly, DMH has structures in place to provide crisis counseling to the general public during times of local or large-scale catastrophic events. For ten years, DMH has had a Director of Emergency Management at its Central Office, Disaster Coordinators in each of its six Areas and a call-up roster of several hundred trained crisis counselors available for deployment. These services, which DMH provides free of charge, consist of acute crisis counseling in the immediate aftermath of an event, accessed via 24/7 DMH Emergency Management contact numbers.

As the state mental health authority, DMH applies for and administers federal disaster mental health grants, most notably the FEMA Crisis Counseling grant in the event of a Presidential Declaration of Disaster. Massachusetts, as one of the states directly affected by September 11, 2001, obtained a FEMA grant to create the MASS Counseling Network Program which provided individual and group counseling and educational presentations for over 80,000 citizens of Massachusetts.

DMH has a multi-year history of shared programs with the Massachusetts Department of Public Health (DPH) and the two departments have shared SAMHSA grant money to enhance all-hazards disaster planning for DMH and the DPH Bureau of Substance Abuse Programs. In 2003, with federal grant guidance mandating inclusion of behavioral health issues in public health disaster preparedness activities, DPH provided DMH with $450,000 from its HRSA grant for disaster preparedness. DMH lost (in SFY'05) but gained (in SFY'06) a Clinical Director for disaster behavioral health who will work with the DPH Emergency Cluster on including psychosocial issues in workgroups on workforce development, surge capacity, risk communication, drills and exercises, and education/training. DMH awarded a contract in SFY'05 for a Crisis Counselor Training Program which will train and credential a new group of clinicians to conduct evidence-informed, culturally competent, developmentally appropriate counseling in the immediate aftermath of disaster through the end of SFY'06. In SFY'07, absent additional federal funding, training will be provided via a train-the-trainer model. DMH and DPH together are developing a menu of trainings in psychosocial issues specific to a variety of audiences, including primary care providers, emergency room personnel, public health staff and public safety officials.

Significance: The Department's enabling statute requires DMH to take cognizance of the mental health needs of the citizens of the Commonwealth.

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Objective I/1/2 A: **Continue efforts to reduce the stigma associated with mental illness (Page 53).**

Brief Name: *Reducing stigma*

AMENDMENT: **1)** EVALUATION MOVED FROM SFY'07 TO SFY'06; **2)** A MASSACHUSETTS-SPECIFIC PSA WILL BE DEVELOPED IN SFY'06; **3)** IN SFY'07, THE EBI CURRICULUM WILL BE MODIFIED AND USED FOR WIDER AUDIENCES.

Indicator: The Elimination of Barriers Initiative and Changing Minds campaigns are implemented through placement of Public Service Announcements, print articles and other outreach activities.

Measure: Public information campaign reduces the stigma associated with mental illness

Year 1: Place and track SAMHSA-supported Public Service Announcements (EBI) for TV, radio and print media in local and statewide media outlets.

Year 2: Participate in evaluation and analysis of EBI campaign. Develop and distribute a Public Service Announcement for Massachusetts audiences.

Year 3: Design and implement educational outreach activities to select audiences, such as the legislative Committee on Mental Health & Substance Abuse.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/2. *Reducing Stigma*					
Value: Stigma associated with seeking help for mental illness is decreased	Compared to 1997, stigma is decreased				Compared to SFY'04, stigma is decreased
Measure: PSAs and articles are placed (Years 1 & 2); **stigma is decreased (Year 3). Effectiveness of campaign is evaluated**	Public opinion survey conducted by MAMH	3 TV, 3 radio, 5 cable, 5 print ads & 2 articles placed	Multiple TV, radio, cable, & articles placed`	Post-EBI evaluation conducted and analyzed; a new PSA is developed.	New educational outreach activities are developed & implemented

Data Source: DMH Division of Clinical & Professional Services; Mass. Association for Mental Health (MAMH)

Background: DMH launched "Changing Minds," a successful statewide anti-stigma campaign in 1997. A survey in SFY'04, commissioned by MAMH, demonstrated that public attitudes have changed since that time and that people are more willing to seek help for emotional problems. There is still a long way to go, however. In 2003,

Massachusetts was selected by SAMHSA as one of eight states to pilot its new anti-stigma campaign called, the "Elimination of Barriers Initiative (EBI)." After much preparatory work, the materials developed and approved by SAMHSA for this campaign were delivered and rolled out in SFY'05. They included PSAs for TV and radio as well as print ads and drop-in articles targeted to the general population. TV and radio viewers and listeners were directed to call a national hotline, which then directed Massachusetts' callers to DMH, MAMH or several other consumer and family organizations for more information, including a bilingual line at DMH. DMH and MAMH were able to track these calls. A more specific campaign, targeted at high school teachers and administrators, was launched also (see C/A Plan for description). DMH has partnered with the Massachusetts Association for Mental Health (MAMH) in this effort. Part of the EBI support includes an evaluation conducted by a national organization.

Funding for EBI ends in the beginning of SFY'06, but DMH and MAMH will continue the "Changing Minds" campaign. This will include developing and promoting a more targeted PSA to be distributed in Massachusetts and designing an educational outreach program that can be presented to select groups, including schools and the recently created legislative Joint Committee on Mental Health and Substance Abuse.

Significance: Decreasing stigma promotes increased utilization of mental health services.

Objective I/2/3 A: Maintain PACT team clients successfully in the community (Page 56).

Brief Name: *PACT team services*

AMENDMENT: **1)** CHANGE MEASURE FOR YEARS 2 AND 3 TO INCLUDE DAYS SPENT IN ANY PSYCHIATRIC HOSPITAL OR UNIT; **2)** ADD EMPLOYMENT MEASURE FOR YEARS 2 AND 3.

Indicator: the percent of adults served by a PACT team who remain in the community.

Year 1: 93% of PACT team clients remain out of the state hospital; *75%* remain in housing; *90%* (who need it) receive substance abuse treatment

Measure 1: $\frac{\text{total \# of psychiatric hospital days for all PACT clients}}{\text{\# of adults served by a PACT team}}$

Measure2: $\frac{\text{\# of PACT team clients who remain in housing, receive needed S/A treatment and find employment}}{\text{\# of adults served by a PACT team}}$

Year 2: *16* days/year/client of psychiatric hospitalization; *80%* of PACT team clients remain in housing; *90%* (who need it) receive substance abuse treatment; *20%* are employed

Year 3: *14* days/year/client of psychiatric hospitalization; *80%* of PACT team clients remain in housing; *90%* (who need it) receive substance abuse treatment; *20%* are employed

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/2/3. *PACT team services*					
Value: the % of adults served by a PACT team who					
remain out of state hospital	**93.4%**	**93%**	**N/A**	**N/A**	**N/A**
remain housed:	**57%**	**75%**	**N/A**	**80%**	**80%**
need & receive S/A Tx:	**95.3%**	**90%**	**N/A**	**90%**	**90%**
are employed:	**N/A**	**N/A**	**N/A**	**20%**	**20%**
# of psychiatric hospital days/year/client: **Note**: New for SFY'06 and '07.	**N/A** (5/13 pgms. reporting)	**N/A**	**N/A**	**16 days**	**14 days**
Numerator: # of adults served by a PACT team who					
remain out of state hospital:	**N/A**	**607/650**	**N/A**	**N/A**	**N/A**
remain housed:	**265/326**	**147/258**	**N/A**		
receive S/A treatment:	**140/165**	**122/128**	**N/A**		
are employed:	**N/A**	**N/A**	**N/A**		
# hospital days/year/client	**N/A**	**N/A**	**N/A**		
Denominator: total # of adults served by PACT teams	**540**	**650**	**717**		

Data Source: DMH Data Warehouse; Performance Based Contracting

Background: For those clients in the community whose multiple problems, including homelessness and non-compliance, may require up to 24-hour intensive oversight to support their functioning, including help with housing and employment, and keeping them out of the hospital, DMH, with Medicaid's assistance, has created 13 PACT teams, statewide. These include eight new teams funded with savings derived from closing Medfield State Hospital. Since recipients of PACT services receive intensive care coordination from the team, these clients do not receive DMH case management services and are not included in the numerator or denominator in Objective I/2/2 (case management).

DMH is changing this indicator to count all psychiatric hospital days used by PACT clients. While PACT teams track number of hospital days accrued annually by PACT clients, they do not differentiate in their reporting between acute, short-term community hospitalization and state hospital admissions. The Planning Council felt strongly that preventing any hospitalization is an important PACT goal. They also decided to add employment as another indicator of successful tenure in the community. Complete data for SFY'05 are not yet available.

Special Issues: Additional funding is necessary to increase the number of case managers and PACT teams.

Significance: Case management and PACT team services provide the integration and coordination necessary to support clients' ability to live independently in the community and reduce the need for hospitalization.

Objective I/4/1 A: **Increase the number of adults living in the community with residential support services (Page 61).**

Brief Name: *Community Residential Services*

AMENDMENT: **1)** REMOVE THE WORD "INDEPENDENTLY" FROM INDICATOR TO REFLECT THAT SOME CLIENTS RECEIVING RESIDENTIAL SUPPORT SERVICES ARE NOT LIVING ON THEIR OWN. **2)** INCREASE % GOAL FOR SFY'06 AND SFY'07.

Indicator: **the percent of DMH clients living in the community with clinical and residential support services**

Measure: # of adults receiving residential support services / # of adults eligible to receive residential support services

Year 1: *68%* of eligible clients (requesting residential services) receive residential services

Year 2: *80%* of eligible clients (requesting residential services) receive residential services

Year 3: *80%* of eligible clients (requesting residential services) receive residential services

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/1. *Community residential services*					
Value: the % of DMH clients living independently with residential support services	**68.1%**	**68%**	**90.2%**	**80%**	**80%**
Numerator: # of adults receiving residential support services	**7,261**		**7,366**		
Denominator: # of adults eligible to receive residential support services	**10,667**		**8,166**		

Data Source: DMH Data Warehouse

Background: The numerator represents an unduplicated number of individuals receiving residential services (both contracted and state-run). The denominator represents all those consumers who are receiving residential support services and those who are eligible and waiting. In addition to increasing residential placements, DMH has made a substantial effort to refine the waiting list and ensure its accuracy, which is reflected in newly calculated waitlist numbers. Although the SFY'03 and SFY'04 budgets sustained significant cuts, DMH made every effort to protect its residential capacity. The increases in capacity in SFY'03 and SFY'04 (over previous years) were due to several factors. The legislature created a separate appropriation in SFY'03 ($3.6 million) for community residential placements for clients leaving Medfield State Hospital as it closed down. Savings from the closure were used to annualize support in SFY'04 and beyond for these new residential placements and for the new PACT teams. An increased legislative appropriation for community placements in SFY'06 assures that the progress will continue.

Significance: Increasing independence and functioning for people with serious mental illness is a primary goal of DMH.

Objective I/4/2-A: Assist adults in obtaining employment (Page 62).

Brief Name: *Employment*

AMENDMENT: **1)** DISCONTINUE REPORTING ON THIS INDICATOR FOR SFY'06. **2)** DETERMINE PLAUSIBILITY OF RE-ESTABLISHING GOAL FOR SFY'07.

Indicator: the percent of adults in DMH-sponsored employment programs placed in jobs

Measure: # of adults from DMH-sponsored employment programs employed
# of adults participating in DMH-sponsored employment programs (SEE & Clubhouse)

Year 1: *56%* (SEE) and *48%* (Clubhouse) of adults participating in DMH-sponsored employment programs are placed in jobs outside the program

Year 2: *Indicator Discontinued*

Year 3: *Indicator To Be Determined*

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/2. *Employment*					
Value: the % of adults in DMH-sponsored employment programs placed in jobs SEE: Clubhouse:	**50.25%** **69.2%**	**56%** **48%**	**N/A** **N/A**	**Discontinue; convene group to establish new goal for SFY'07**	**TBD**
Numerator: # of adults employed from SEE: Clubhouse: employment programs	**501** **2,037**				
Denominator: # of adults participating in employment programs. SEE: Clubhouse:	**997** **2,944**				

Data Source: Performance Based Contracting Database

Background: The SEE program (Services for Employment and Education) is a flexible, community-based service that provides access to an array of employment, skill training and educational opportunities for DMH clients. A range of employment services,

including transitional, supported and independent employment *also* is provided in clubhouses. DMH provides the majority of funding for clubhouses in the state, and the clubhouses abide by standards that define their mission, membership and programs. Although most clubhouse members are referred by DMH and meet DMH eligibility criteria, members are not required to formally apply for DMH client eligibility to participate in the clubhouse programs. One of the felt needs in the area of employment is to improve DMH's ability to track employment tenure, in addition to placement.

Because of ongoing changes in the methods and indicators used in the field to collect employment information, more refinement is necessary before DMH can be assured that it is collecting and reporting the data accurately. Employment data that are available from SEE programs and clubhouses will be reported in the narrative in SFY'06. The intention in SFY'07 is to develop a target that is based on more accurate employment data. Complete data for SFY'05 are not yet available.

Significance: Employment is a means of enhancing self-esteem and independence and increasing community tenure for people with serious mental illness.

Objective I/4/4 A: Increase level of functioning for inpatients and community clients (Page 66).

Brief Name: *Improved functioning*

AMENDMENT: CREATE NEW MEASURE FOR YEARS 2 AND 3 TO DIFFERENTIATE BETWEEN ONGOING INPATIENTS AND PATIENTS BEING DISCHARGED.

Indicator: the percent of adults receiving extended stay inpatient services and/or case management services with increased functioning at periodic reviews (inpatient) or at the annual Individual Service Plan (ISP) review (community) as measured by the CERF R (Current Evaluation of Risk and Functioning-Revised)

Measure 1: *Continuing Inpatients*: # of adults remaining on extended stay inpatient units who, at periodic review, show increased functioning in at least one of 8 selected domains on most recent CERF-R
# of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission on any of 8 selected domains (A. ADL; E. Social; F. Independence; H. Medications; I. Negotiate Hazards; J. Violence – Others; L. Violence – Self; N. Substance Abuse)

Measure 2: *Patients at Discharge*: # of adults being discharged from extended stay inpatient units who show increased functioning in at least one of 8 selected domains on CERF-R at time of discharge
# of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission on any of 8 selected domains (A. ADL; E. Social; F. Independence; H. Medications; I. Negotiate Hazards; J. Violence – Others; L. Violence – Self; N. Substance Abuse)

Measure 3: *Community*: # of adults in the community showing increased functioning in at least one of 8 selected functional domains on the CERF-R at annual ISP review

# of adults with an ISP given the CERF-R who scored 4 or more on previous CERF-R in any of 8 selected domains (A. Hygiene; B. Nutrition; E. Negotiate Social Situations; F. Pursue Independence; G. Use Recovery Services; H. Use Psychiatric Meds; I. Recognize/Avoid Common Hazards; Q. Get/Use Medical Services).

Year 1: *Continuing Inpatient*: Improve level of functioning/reduce risk. At periodic review CERF-R, score is increased in at least one of 8 selected domains where the patient scored a 5 or 6 at admission.

Community: Level of functioning at ISP annual review CERF-R is increased in at least one domain where the client scored a 4, 5 or 6 on any of 8 selected domains on the previous CERF-R.

Year 2: Same as Year 1 for community clients (Measure 3). **Add Measure 2 for inpatient units to differentiate between** level of functioning scores for those patients being discharged with those patients not ready for discharge who remain in the hospital;

Year 3: Same as Year 2.

NOTE: Both *functional* and *risk* domains from CERF-R were selected for inpatients, because many patients have serious *risk* issues at hospital admission. On the other hand, only *functional* domains were selected for the community clients because such a small percentage of community clients have high risk scores that to include risk domains would not give a representative sample of the issues for the vast majority of community clients.

Data Source: DMH Data Warehouse

Background: The CERF-R is used on all extended stay inpatient units and with every case managed DMH client in the community. A multidisciplinary team (inpatient) or team of providers and case manager (community) typically administers the CERF-R. CERF-R is administered to patients on inpatient units at the time of admission, at 3 and 6-month periodic reviews, at the annual review and at discharge. CERF-R is administered to community clients at the time of ISP development and at the ISP annual review. A score of 5 or 6 would indicate a relatively low level of functioning which would presumably improve after a period of hospitalization and be significantly improved at the time of discharge. A score of 4 or more (community clients) would trigger authorization of community services that would presumably improve functioning. Inpatient implementation of CERF-R occurred in SFY'00; and phased community implementation began in SFY'01. Complete data for SFY'05 are not yet available.

Significance: Mental health services are expected to improve a person's ability to function in his/her environment. The CERF-R measures various domains related to autonomy and risk.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/4. *Improved functioning*					
Value: % adults with increased functioning (inpatient) Discharged patients: Continuing care patients:	**75% (all)**	**50% (all)**	**N/A**	 **70%** **50%**	 **70%** **50%**
Numerator: b) # adults on extended stay inpatient units with increased functioning on CERF-R at most recent periodic review: a) # adults on extended stay inpatient units with increased functioning on CERF-R at discharge:	**450**		**N/A**		
Denominator: # of adults on extended stay inpatient units given the CERF-R who scored 5 or 6 at admission	**600**	**600**	**N/A**		
Value: % adults with increased functioning (community)	**66%**	**50%**	**N/A**	**50%**	**50%**
Numerator: # of adults with an ISP with increased functioning at annual ISP review	**780**	**780**	**N/A**		
Denominator: # of adults with an ISP given the CERF-R who scored 4 or more on previous CERF-R	**1,182**	**1,182**	**N/A**		

Objective I/7 A: Survey consumers to assess whether DMH services result in improved outcomes (see Amendment below).

Brief Name: *Consumer Satisfaction*

AMENDMENT: THIS IS THE AMENDMENT TO THE 2005-2007 PLAN THAT WAS SUBMITTED TO CMHS AFTER THE OCTOBER 2004 REVIEW. IT HAS BEEN UPDATED FOR 2007.

Indicator: the percent of adults who report improvement in symptoms, functioning and/or quality of life as a result of receiving DMH services

Measure: # adults who report improvements in their symptoms, functioning and/or quality of life
adults surveyed

Year 1: Conduct research to select a tool and methodology for carrying out a statewide consumer satisfaction survey

Year 2: Based on recommendations of research group, select a tool and methodology and begin data collection and analysis based on completed pilot survey

Year 3: Review results of '06 survey and methodology; re-tool if necessary; select services and population to be surveyed. Conduct statewide survey and analyze results.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/7-A. *Consumer Satisfaction*					
Value: the % of adults who report improvements in symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**Select tool and methodo-logy**	**RFR issued to select tool and methodology**	**Pilot survey; collect and analyze data**	**Review '06 statewide pilot; select new services; conduct survey**
Numerator: # of adults surveyed, who report improvements	**N/A**				**N/A**
Denominator: # of adults surveyed	**N/A**			**1,500**	**1,000-1,500**

Data Source: Divisions of Clinical & Professional and Mental Health Services
See narrative under child/adolescent indicator.

CHILD AND ADOLESCENT INDICATORS

Objective I/1/1 C/A: **Prepare for coordinating and delivering mental health services in the event and/or aftermath of a natural or man-made disaster (Page 78).**

Brief Name: *Disaster Management*

AMENDMENT: CHANGE YEAR 3 GOAL TO REFLECT EXPIRATION OF FEDERAL GRANT AND CONSEQUENT MOVE FROM DIRECT TRAINING TO TRAIN-THE-TRAINER MODEL.

Indicator: DMH collaborates with its community partners to foster resilience and preparedness, and increase stress management skills among children and adolescents and their families before any untoward event.

Measure: The Commonwealth prepares for and responds to the mental health needs of its citizens in the event of a disaster.

Year 1: Develop an evidence-based, culturally competent and developmentally appropriate program to train licensed mental health professionals to respond appropriately and quickly in the event of a natural and/or man-made disaster; train 75 crisis counselors per quarter.

Year 2: Continue to train 75 crisis counselors per quarter; develop official credentialing criteria for crisis counselors and integrate their certification with certification criteria being developed by DPH for health care volunteers.

Year 3: Continue to train crisis counselors using a train-the-trainer model; identify trained DMH crisis counselors in each DMH Area to function as liaisons with regional DPH and Department of Homeland Security planning groups to ensure that behavioral health issues are included in all aspects of disaster planning and management.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/1. *Disaster Management*					
Value/Measure: Massachusetts prepares for and responds to the mental health needs of its citizens in the event of a disaster	DPH grant received; DMH role defined	Training curriculum designed; 75 clini-cians/Q trained	Training curriculum designed; 355 clini-cians trained	Credential process designed; 75 clini-cians/Q trained	DMH-DPH-DHS liaison created; clinicians trained

Data Source & Background: Please see adult narrative, page 30, in this document.

Objective I/1/2 C/A: **Continue efforts to reduce the stigma associated with mental illness and serious emotional disturbance (Page 79).**

Brief Name: *Reducing stigma*

AMENDMENT: **1)** EVALUATION MOVED FROM SFY'07 TO SFY'06; **2)** IN SFY'06, THE EBI CURRICULUM WILL BE MODIFIED AND IN SFY'07, OTHER EDUCATIONAL OUTREACH EFFORTS WILL BE USED FOR WIDER AUDIENCES.

Indicator: Attitudes of school teachers and administrators toward mental health issues are improved.

Measure: Anti-stigma activities are implemented in selected schools across the Commonwealth

Year 1: Training on the EBI school curriculum is provided to teachers and administrators in four pilot high schools. The curriculum is included as in-service training to the professional staff in these four schools.

Year 2: Participate in evaluation and analysis of EBI campaign. Develop and continue outreach activities to the education community to increase awareness about mental illness and the effectiveness of treatment.

Year 3: Continue outreach activities to schools and other community groups.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/1/2. *Reducing Stigma*					
Value/Measure: Anti-stigma activities improve attitudes of school personnel in the Commonwealth	**EBI materials developed; pilot schools recruited**	**Training provided to four schools**	**Training provided to four schools**	EBI evaluation conducted; new outreach activities are developed & implemented	Outreach activities are provided to schools and other community groups

Data Source: DMH Office of Policy Development; Mass. Association for Mental Health

Background: DMH launched a successful statewide anti-stigma campaign in 1997. A survey conducted in 2004 demonstrated that public attitudes have changed since that time and that people are more willing to seek help for emotional problems. In 2003, Massachusetts was selected by SAMHSA as one of eight states to pilot its new anti-stigma campaign called, "Elimination of Barriers Initiative (EBI)." In addition to PSAs for TV and radio and print articles targeted to the general population, a more specific campaign, which included a curriculum approved by SAMHSA for high school teachers and administrators, was rolled out in SFY'05. DMH has partnered with the Massachusetts Association for Mental Health in this effort. After EBI concludes in

September 2005, DMH and MAMH will continue to develop and implement anti-stigma activities, including the EBI curriculum, in schools and with other community groups in SFY'06 and SFY'07 to increase awareness about mental illness and the effectiveness of treatment.

Significance: Decreasing stigma promotes increased utilization of mental health services.

Objective I/5/7 C/A: Survey consumers and families to assess whether DMH services result in improved outcomes (see Amendment below).

AMENDMENT: THIS IS THE AMENDMENT TO THE 2005-2007 PLAN THAT WAS SUBMITTED TO CMHS AFTER THE OCTOBER 2004 BLOCK GRANT REVIEW. IT HAS BEEN UPDATED FOR SFY'07.

Brief Name: *Consumer Satisfaction*

Indicator: the percent of youth and families who report improvement in symptoms, functioning and/or quality of life as a result of receiving DMH services

Measure: # youth who report improvements in their symptoms, functioning and/or quality of life
youth surveyed

Measure: # families who report improvements in their children's symptoms, functioning and/or quality of life
families who respond to survey

Year 1: Conduct research to select a tool and methodology for carrying out a statewide consumer satisfaction survey

Year 2: Based on recommendations of research group, select a tool and methodology and begin data collection and analysis based on completed pilot survey

Year 3: Review results of '06 survey and methodology; re-tool if necessary; select services and population to be surveyed. Conduct statewide survey and analyze results.

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/7. *Consumer Satisfaction*					
Value: the % of youth who report improvements in symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**Select tool and methodology**	**RFR issued to select tool and methodol-ogy**	**Pilot survey; collect and analyze data**	**Review '06 statewide pilot; select new services; conduct survey**
Numerator: # of youth surveyed, who report improvements	**N/A**				
Denominator: # of youth surveyed	**N/A**			**250**	**250**
Value: the % of families who report improvements in their child's symptoms, functioning and/or quality of life as a result of receiving DMH services	**N/A**	**Select tool and methodology**	**RFR issued to select tool and methodol-ogy**	**Pilot survey; collect and analyze data**	**Review '06 statewide pilot; select new services; conduct survey**
Numerator: # of families surveyed, who report improvements	**N/A**				
Denominator: # of families surveyed	**N/A**			**250**	**250**

Data Source: DMH Divisions of Clinical & Professional and Mental Health Services

Background: For a number of years, DMH has contracted with Consumer Quality Initiatives, Inc. (CQI), a Boston-based consumer-run organization, to conduct consumer satisfaction surveys in some of its programs. Included were adult DMH inpatient, case management, residential and PACT programs, to name a few. These surveys, which are conducted via face-to-face interviews, have been well received. In addition, every program (i.e., adult, child and adolescent) that contracts with DMH is required to survey its own service recipients to assess satisfaction with the program. Programs report the results annually to DMH through Performance Based Contracting (PBC) and the results are compiled in the PBC database. However, the PBC program-based surveys have never been tested for validity and reliability.

In order to collect satisfaction and outcome data for the block grant and for URS Table 11, DMH will begin, in SFY'05, to develop a more comprehensive plan for conducting a statewide consumer survey, using a tool that has been tested and proven reliable. DMH issued a Request for Responses in SFY'05 to research the tools and methodologies available for conducting this kind of survey, which resulted in planning

recommendations prepared by two academic centers and an experienced consumer-run survey organization. Using this information, DMH ultimately contracted with the University of Massachusetts Medical School to refine the tools and pilot the survey statewide in SFY'06. A random sample of about 1,500 consumers and family members who were receiving four different DMH-funded services was selected to participate. After the methodology and results from the SFY'06 effort are analyzed, another statewide survey will be conducted in SFY'07. It is anticipated that the results of the survey will be used to inform program development and service delivery. Children and adolescents and their families, and adults, have been invited to participate in the survey.

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Objective III/1 C/A: Provide coordinated care to children whose needs require interventions under the jurisdiction of more than one child-serving agency (Page 118).

1(b) Brief Name: *Interagency care coordination*

AMENDMENT: CHANGE THE MEASURE TO REFLECT THE REPLACEMENT OF WCC BY THE FIVE CFFC SITES.

Indicator: the number of children and adolescents receiving interagency care coordination

Measure: # of children & adolescents enrolled in the MHSPY and WCC programs in SFY'03 (baseline)

Year 1: *170* C&A receive interagency care coordination through MHSPY & WCC

New Measure: **# of children & adolescents enrolled in the MHSPY and CFFC programs (new baseline established in SFY'06)**

Year 2: *330* C&A receive interagency care coordination through MHSPY & CFFC

Year 3: *330* C&A receive interagency care coordination through MHSPY & CFFC

Performance Measures:	**SFY'04 Actual**	**SFY'05 Goal**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
III/1(b) C-A. *Interagency care coordination*					
Value: the # of children and adolescents receiving interagency care coordination	**176**	**170**	**155**	**330**	**330**
Measure: # of children & adolescents enrolled in the *MHSPY & WCC programs in SFY'03 (baseline) *MHSPY & CFFC (SFY'06)	**153**	**153**	**153**		

Data Source: MHSPY, WCC and CFFC tracking systems

Background: The Mental Health Service Program for Youth (MHSPY), a Robert Wood Johnson Foundation replication project, and Worcester Communities of Care (WCC), funded in part through a Child Mental Health Initiative grant from the Center for Mental Health Services, are interagency projects aimed at keeping children in their communities. The programs provide intensive wraparound services and clinical care coordination. The federal grant for WCC officially ends September 30, 2005. However, the essence of the WCC program has been incorporated into the MassHealth-administered CFFC program (Coordinated Family-Focused Care) that is operating as a pilot in five cities. WCC has become a CFFC site.

Both MHSPY and CFFC are state-funded programs that serve children who are Medicaid clients at-risk of out-of-home placement. MHSPY serves children from the communities of Cambridge, Somerville, Malden and Everett enrolled in the Neighborhood Health Plan HMO and is expected to serve 80 children in SFY'06. CFFC serves children from Worcester, Lawrence, Brockton, Springfield and New Bedford. In SFY'06 and '07, each CFFC site is expected to serve 50 children.

Significance: Maintaining children in their natural environment, unless contraindicated, is considered best practice and is a primary goal of the mental health block grant.

MARCH 2006 AMENDMENTS TO 2005-2007 PLAN

ADULT INDICATORS

Goal I/4 A: Adults with serious mental illness achieve maximum independence and highest functioning.

Objective I/4/1 A: **Increase the number of adults living in the community who are receiving residential support services (Page 61).**

Brief Name: *Community Residential Services*

Indicator: the percent of DMH clients living in the community receiving residential support services

Measure: # of adults receiving residential support services
# of adults determined to need residential support services

Year 1: *68%* of DMH clients determined to need residential support services who receive residential support services

Year 2: *80%* of DMH clients determined to need residential support services who receive residential support services

Year 3: *79%* of DMH clients determined to need residential support services who receive residential support services

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
I/4/1. *Community residential services*					
Value: the % of DMH clients determined to need residential support services who received them	**71%**	**68.1%**	**90.2%**	**80%**	**79%**
Numerator: # of adults receiving residential support services	**8,429**	**7,261**	**7,366**		
Denominator: # of adults eligible to receive residential support services	**11,829**	**10,667**	**8,166 (receiving services + WL)**		

Data Source: DMH Data Warehouse

Background: The numerator represents an unduplicated number of individuals receiving residential services (both contracted and state-run). The denominator represents all those consumers who are receiving residential services and those who are eligible and waiting. In addition to increasing residential placements, DMH has made a substantial effort to refine the waiting list and ensure its accuracy, which is reflected in newly calculated waitlist numbers. Although the SFY'03 and SFY'04 budgets sustained significant cuts, DMH made every effort to protect its residential capacity. The increases in capacity in SFY'03 and SFY'04 (over previous years) were due to several factors. The legislature created a separate appropriation in SFY'03 ($3.6 million) for community residential placements for clients leaving Medfield State Hospital as it closed down. Savings from the closure were used to annualize support in SFY'04 and beyond for these new residential placements and for the new PACT teams. In SFY'05, significant work was done to assess the accuracy of the waiting list and to further assess, on an Area by Area basis, the real need for increased residential support services for DMH clients. It was determined, after this exercise, that there were 800 clients waiting for these services.

March 2006 change: A decrease of $150,000 to the adult residential services account resulting from a reduction in federal block grant funding in FFY'06 means that up to ten (10) fewer clients will receive residential services and supports in the community when these cuts are implemented. Per client costs for residential services average $25,000/year and range from minimal support services to intensive services needed after discharge from a state hospital.

Residential services may include housing, support, supervision, treatment and rehabilitation services to clients living in the community, such as symptom management, supportive counseling, medication education, skills training and support regarding management of co-occurring disorders, problem solving related to activities of daily living, social and recreational skill training, skills for transition to independent living, pre-vocational skills training, educational support, wellness promotion, money management, assistance with exploring housing options, medication administration.

Goal II/1 A: Increase availability of community-based mental health services

Objective II/1-A: Increase the number of DMH clients who receive a continuing care community service (Page 99).

Brief Name: *Service capacity*

Indicator: the percent of adults who receive a continuing care community mental health service

Measure: # of adults who received a DMH continuing care community service
adults eligible for DMH continuing care community services

Year 1: *87%* of eligible adult clients will receive at least one DMH community service.

Year 2: *87%* of eligible adult clients will receive at least one DMH community service.

Year 3: *86%* of eligible adult clients will receive at least one DMH community service.

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Actual**	**SFY'06 Goal**	**SFY'07 Goal**
II/1 *Service capacity*					
Value: % adults who receive at least one continuing care community service	**97%**	**87.3%**	**90.2%**	**87%**	**86%**
Numerator: # of adults who received a DMH continuing care community service	**20,290**	**17,297**	**17,534**		
Denominator: # adults eligible for DMH continuing care community services	**20,992**	**19,806**	**19,429**		

Source of Information: DMH Data Warehouse

Background: DMH's enrolled population refers to those who apply for and are determined eligible for DMH continuing care community services, for whom no other options, outside of DMH, exist. DMH services include residential, PACT, case management, day, outpatient, educational and employment services, and other community services, such as community rehabilitation support. After being found eligible to receive DMH community services, each individual is assigned to services according to priority of need. If no appropriate community service is available, the individual is placed on a waiting list and is contacted on a regular basis regarding wait status. *Please note that the numerator above includes clients receiving PACT team services but not individuals receiving inpatient, outpatient or forensic services only, or Clubhouse members, if Clubhouse is the only service they use. DMH does not require adults solely participating in Clubhouse programs to apply for DMH eligibility and does not include them in its Client Tracking System, even though they are usually referred to the Clubhouse by DMH.*

March 2006 change: A decrease of $110,000 to the adult community rehabilitative support account resulting from a reduction in federal block grant funding in FFY'06 means that as many as 39 fewer clients will receive community rehab support services when these cuts are implemented. Per client costs for community rehabilitation support services average $2,800/year.

Community rehab support services include: efforts to engage hard to reach clients, outreach to shelters and transitional residential programs, assistance in locating housing, skills training, money management services, teaching use of community resources, applying for entitlements, securing medical and employment services, accessing self-help options, transportation, intensive short term support to stabilize behavior, client and family education, case coordination, direct and indirect assistance with medication.

SEPTEMBER 2006 AMENDMENTS TO 2005-2007 PLAN

ADULT INDICATORS

Objective I/5/2 A: **Ensure that adults referred from acute care hospitals to DMH are either admitted for hospital level of care (LOC) or diverted to a less restrictive, clinically appropriate community-based alternative. (Page 69)**

Brief Name: *Inpatient referrals*

AMENDMENT: NEW GOAL REFLECTS ACTUAL STATEWIDE ADMISSIONS DATA SHOWING A DECREASE IN HOSPITAL ADMISSIONS AND AN INCREASE IN COMMUNITY DIVERSION (2004 DATA WAS BASED ON ONE AREA ONLY).

Indicator: the percent of individuals referred from acute care to DMH and admitted to hospital LOC or diverted to a clinically appropriate community alternative

Measure: # of hospital admissions & community diversions
# of referrals to DMH from acute care

Year 1: *80%* of non-forensic patients admitted for hospital LOC; *20%* diverted to community alternative

Year 2: *80%* of non-forensic patients admitted for hospital LOC; *20%* diverted to community alternative

Year 3: *70%* of non-forensic patients admitted for hospital LOC; *17%* diverted to community alternative

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Actual**	**SFY'06 Projected**	**SFY'07 Goal**
I/5/2. *Inpatient admissions*					
Value: % referrals admitted for hospital LOC: diverted to community: other or pending:	**N/A**	**80%*** **20%***	**70%** **12.4** **17.6%**	**67%** **18%** **15%**	**70%** **18%** **12%**
Numerator: # of hospital admissions: community diversions: other or pending:	**N/A**	**84*** **21***	**414** **73** **101**		
Denominator: # of referrals to DMH from acute care	**N/A**	**105***	**588**	**584**	

***Data Source**: Clinical & Professional Services database.

Background: Admission to DMH extended stay inpatient facilities is based on published, uniform clinical criteria and available beds. Referrals are accepted from all acute hospitals as well as from the courts. All forensic patients are admitted. When indicated, DMH staff, e.g., case managers, PACT team, housing specialists, work intensively with non-forensic patients from the referring acute care hospital to find an appropriate alternative to hospital level of care. This may include return to a residence, with necessary support, crisis step-down or community respite care.

The SFY'04 data above were from a single DMH Area, Metro Suburban - the largest area in the state. These data were "cleansed" to remove extraneous factors that incorrectly contaminated previous statewide data, such as forensic referrals and referrals from the acute facility that were withdrawn. The SFY'05 Implementation Report and the projection for SFY'06 include data for all six DMH Areas. Based on this information, the SFY'07 goal was recalculated. Data from SFY'06 suggest that in addition to the 67% who were admitted, another 14% remained in acute care or had applications for admission pending. The remaining patients were discharged to the community. Therefore, the goal for SFY'07 admissions is 70%, a realistic target for those who meet DMH clinical criteria and are determined to be in need of continuing inpatient care.

Significance: Access to services is a major goal of DMH. The central aim of service delivery is to integrate public and private services and resources to provide continuity of care.

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Objective I/5/5 A: **Encourage the use of Emergency Service Programs (ESP) by elders (>65), particularly elders-at-risk, by ensuring that ESPs have staff that is knowledgeable and experienced in working with elders. (Page 72)**

Brief Name: *Elder emergency services*

Indicator: the number of elders who are screened and evaluated by an ESP

Measure: # of elderly individuals who are screened and evaluated by an ESP

Year 1: ESPs are assessed for their capability to screen and evaluate elders with appropriately trained staff and provide home visits

Year 2: Recontracting process requires ESPs to assure that staff have specialized knowledge and training to screen and evaluate elders, at the ESP site or at home, and to monitor compliance with this expectation; a baseline is established to determine # of elders who contact an ESP and are screened and evaluated

Year 3: New (Medicaid) contract with vendor includes Year 2 goal as a measurable performance indicator; expectation is that there will be an increase in the # of elderly individuals who are screened and evaluated by an ESP

Performance Measures:	**SFY'03 Actual**	**SFY'04 Actual**	**SFY'05 Actual**	**SFY'06 Projected**	**SFY'07 Goal**
I/5/5. *Elder emergency services*					
Value: # elders who are screened and evaluated by an ESP	**N/A**	**N/A**	**Survey is completed; baseline is established (2% of total encounters)**	**DMH submits performance indicator to Medicaid for ESP contract**	**# elders screened & evaluated increases over baseline**

Data Source: MBHP Database and DMH Warehouse (for state-operated programs)

Background: As of SFY'05, very few elders or elder-serving agencies were using ESPs, which could play a significant role in helping elders to stay in the community - out of nursing homes and not involuntarily committed to hospitals - with proper supports. There are a number of reasons why elders have not sought or received adequate or appropriate mental health services. One reason is stigma. A second reason is that there has been little awareness in the elder community that this service exists and confusion as to who is eligible to use it (i.e., Medicare, uninsured). The other is that services tailored to their particular needs, provided by staff trained and knowledgeable in serving them, may not be available. It is particularly important that elders-at-risk, i.e., those unable to provide self-care, are screened, evaluated and appropriately referred. In addition to increasing the accessibility of this resource (ESP), it will be important to educate elders and elder-serving agencies to assure its appropriate and continued use.

After gathering data from all the ESPS in SFY'05, DMH submitted a performance indicator to Medicaid in SFY'06 for their new ESP contract (SFY'07) to increase the competencies (concerning elders) of ESP staff and clarify the ESPs' responsibilities for this population. This was accomplished through linkage with the Executive Office of Elder Affairs and the coalition of advocates that are working with DMH to develop an elder mental health plan for the Commonwealth. DMH also used a small SAMHSA grant to develop and publish a guide for elders with mental health problems, their families and caregivers to combat stigma and increase knowledge of specialized resources.

Significance: Increasing access to services is a major goal of DMH.

Criterion V: Management Systems

Financial and staffing resources, including human resource development of community mental health providers that will be available to implement the plan. The plan must also describe the manner in which the state intends to expend the mental health block grant.

This criterion has a single narrative of issues common to adults and children. The goals and performance measures at the end of the narrative are age-specific (Page 130).

The Department of Mental Health is mandated to target its services to the most seriously mentally ill citizens of the Commonwealth through an array of services providing treatment, support and structured skills development. This array includes inpatient, as well as case management, day/vocational, residential, outpatient and peer and family support services. The goal of the Massachusetts service delivery system is to assist DMH clients to achieve and maintain the highest possible level of functioning so they may live and work in the communities of their choice.

The conceptual framework recognizes that the mental health needs of individuals are unique and change over time. In order to respond to these changing needs, the service system must be flexible, culturally competent, and offer treatment for symptoms of mental illness, as well as rehabilitation and supportive services to assist each individual in coping with the functional disabilities resulting from his/her illness. The Department also recognizes the need to work with families and the community at large to provide a supportive environment.

The estimated SFY'07 state appropriation is *$646.6* million, with *73 percent* committed to community-based care. This is an increase of *.3 percent* over SFY'06. The SFY'07 direct services budget is *$607.6* million, of which *$72.5* million is specifically earmarked for child and adolescent services. Of the total state appropriation, *$169.5* million is targeted for child, adolescent and adult inpatient services in state hospitals (includes three contracted adolescent units), state-operated community mental health centers and one adult contracted extended stay hospital unit.

DMH clients receive services from state-operated and/or vendor-run programs. The majority of the state-operated programs provide continuing inpatient care in state facilities, although inpatient care accounts for only *25.4 percent* of the DMH budget. Most community services are provided through program contracts with providers. As of August 15, 2006, DMH estimates that there will be contracts in place for SFY'07 for *404* adult programs ($294.3 million), *189* child and adolescent programs ($78.4 million) and *27* mixed (generic adult/child) programs ($10.8 million).

Financial Resources

Revenue generation is a significant factor in supporting the Department's budget. Since 1988, DMH has significantly increased the amount of revenue it generates from its state hospitals, CMHCs and intensive residential treatment programs, as well as from Medicaid Rehab Option and case management services for DMH Medicaid-eligible clients. Estimated cash revenue in SFY'07 is *$109.1* million, compared with *$8.7* million

in SFY'88. With the exception of revenue from the CMHCs, which is retained by DMH in statutorily created trust funds under the Department's control, and a small retained revenue account for occupancy fees, all other revenue goes to the General Fund (state treasury). However, since the Department's final state appropriation is evaluated by the legislature on a net state cost basis, revenue generation is a significant factor in supporting the Department's budget.

Human Resources

At the end of SFY'06, DMH directly employed *3811* FTEs (compared with *3,826* at the end of SFY'05). DMH continues to work with state-operated facilities as well as vendor-run programs to increase the availability of qualified culturally diverse staff. DMH also provides training for state and vendor staff to provide the knowledge and enhanced skills needed to implement various departmental initiatives.

DMH continues to analyze staff-to-patient ratios in DMH inpatient facilities. Coupled with a revised classification system for inpatient populations, this analysis allows DMH to better review staffing patterns and manpower needs across its facilities, and also is used to support budget and internal resource requests as necessary.

The Department is actively involved in efforts to increase diversity in the workforce, create a workplace that values and respects the individual diversity of staff, and ensure cultural competency in its programs and services. Each Area's Diversity Committee has developed and is implementing a plan to recruit and train staff, support local DMH Cultural Competence initiatives that support and celebrate diversity, and find creative ways to support affirmative marketing programs.

Training

In-service training for staff continues to take place at the local level, including annual statewide training on HIV/AIDS and Infection Control, on Human Rights, Client Abuse Reporting, Workplace Ethics, the Health Insurance Portability and Accountability Act (HIPAA), and on new DMH policies as needed. Four trainings for case managers, on topics identified by a Case Management Training Workgroup, are held each year. DMH also provides difficult-to-treat and psychopharmacology case consultations, upon request, through its Area Medical Directors. Although statewide conferences have been curtailed in recent years due to budget constraints, the Areas continue to hold conferences on topics as varied as cultural diversity, motivational interviewing, dual diagnosis, elder mental health issues, transitional age youth, and ethics. DMH continues its commitment to increase diversity in the workforce and create a workplace that values and respects the individual diversity of staff. In support of this, a series of Interviewing Skills workshops were held this year in an effort to develop management skills that facilitate the recruitment and hiring of diverse workforce members. In addition, each Area's Diversity Committee has a plan to recruit and train staff, and support local DMH Cultural Competence initiatives that support diversity.

In SFY'05, DMH received a three-year federal SAMHSA grant to reduce/eliminate restraint and seclusion in its adult inpatient facilities. New regulations on the Prevention of Restraint and Seclusion and Requirements when used were issued in April 2006. Implementation was supported by two large training events for all of its adult inpatient

units/facilities, as well as an additional large training event for child/adolescent units/facilities. In addition, a training plan consisting of 10 short training modules has been developed. Training on three of the modules (The Regulations, Compassionate Alternatives and Techniques, and an Introduction to Mental Illness) was delivered to staff of DMH-operated inpatient facilities in Spring, 2006. Training on the remaining modules will be delivered during SFY '07.

Provider conferences, grand rounds, and monthly roundtable discussions for the state-operated adult inpatient facilities continued in SFY'06. The discussions focused on the effect of the Restraint Reduction Initiative (RRI) on the unit milieu and were open to inpatient staff and consumers. Also in SFY'06, two 2-day NTAC national trainings were held in Massachusetts for all child-serving programs, and adult, child and adolescent inpatient units licensed by DMH entitled "Creating Coercion-Free Mental Health Treatment Environments." Finally, there were monthly mini-site visits to all 11 state inpatient facilities to problem-solve RRI issues, view data and validate progress toward RRI goals.

In SFY'07, DMH will continue the roundtable discussions, and may resume the mini-site visits. NTAC is planning two training visits to the state, in October at Taunton State Hospital, and in January at Westboro State Hospital. Under the auspices of its grant, DMH will be providing training/consultation to all the facility treatment teams, as well as participating in a national aggregate data collection effort that will support research into the efficacy of an evidenced based practice for restraint reduction. The grant is also being used to support the purchase of sensory equipment and supplies to further implement the initiative.

DMH is in the fourth year of a five-year contract with eight medical school-affiliated programs to train adult, child and forensic psychiatric residents and psychology interns and fellows and meets semi-annually with the training directors to ensure fidelity to the training concepts and curriculum expectations in the contract. Beginning in the fall of SFY'07, senior staff from DMH will make site visits to all of the training programs to personally assess the programs.

Effective intervention requires a coordinated response from all those involved in identifying people with mental illness in the community and those most likely to be involved in a crisis response. Police and emergency room personnel are primary targets for community training activities, with probation officers, hospital security staff, school counselors, community substance abuse treatment providers and emergency medical personnel also invited to attend. Through an interagency service agreement with the Department of Public Health, DMH is actively involved in disaster and emergency management planning and has hired a fulltime emergency management coordinator and assistant specialist in emergency management and disaster intervention.

Each of the DMH Areas and/or Sites has developed its own training plan for SFY'07. Topics to be delivered include: Relapse Prevention, Treatment Planning Goals, Recovery and Vocational Development, and Peer Support Services.

The DMH Forensic Division provides specialized training for court clinicians, community providers and non-mental health personnel. *Court clinician* training provides foundational education for clinicians involved with both juveniles and adults in the public sector forensic system in Massachusetts. The curriculum is part of a program of specialized training for certification required when conducting court-ordered forensic evaluations in court clinics and hospital settings. Topics include: The Massachusetts Social Service System; Legal Systems; Statutes and State/Federal Regulations; Cultural Awareness for working with forensic populations; Ethical Issues in Adult and Juvenile Forensic Services; Violence Risk Assessment; Expert Testimony; and Forensic Report Writing.

Training for *community providers* and DMH case managers provides knowledge and skills to aid in the treatment and management of clients with histories of physical or sexual violence and/or criminal involvement. The curriculum includes: An Overview of the Criminal Justice System; Community Management and Treatment of Sex Offenders; Management of Safety and Risk with Persons having Mental Illness and Substance Abuse Issues; and Understanding the Effects of Prison/Jail Culture.

Training for *non-mental health personnel*, in collaboration with other state agencies, has been provided to police, probation, emergency teams, House of Corrections personnel and Department of Correction caseworkers. The content included facts about mental illness, as well as information regarding M.G.L. Chapter 123 and the role of the Forensic Transition Team in release planning.

Block Grant Spending Plan

The block grant represents about *1.8%* of the projected SFY'07 total budget support for community mental health services. These funds are targeted to a range of community mental health programs for adults with serious mental illness and children and adolescents with serious emotional disturbance. Services supported by the block grant are an integral part of the community mental health service delivery system and an important means of developing a comprehensive service system for all individuals in need of publicly funded care. The Department was notified in March 2006 that its FFY'06 block grant award was decreased by *$323,028.* We were subsequently informed of an addition (due to an error) of *$33,699* and then in the summer of an additional reduction of *$5,649.* As a result, DMH modified its performance indicators in March 2006 to reflect the decrease in service funds. The changes were made to adult residential services and community rehabilitation support. These reductions were in addition to the FFY'05 reduction of *$172,238,* which resulted from a change in the block grant allocation formula. This was the first time that DMH took the step of reducing its performance targets.

The following tables provide a description of state activities under the block grant and a projection of block grant spending for FFY'07. Block Grant funds are awarded on a federal fiscal year basis and the state has two years in which to obligate and expend the funds. Block grant funds are expended on the state fiscal year (SFY) cycle (July 1 to June 30) which differs from the federal fiscal year (October 1 to September 30).

Table One shows the specific services purchased with block grant funds, including child and adolescent services. DMH has allocated *$2.61* million of the grant for FFY'07

for child/adolescent services and continues to comply with the allocation set-aside for these clients. In addition, the state has ensured that when it comes to state expenditures, the level of services allocated for children and adolescents has been maintained.

Table Two indicates the service delivery areas involved. Proposals and contracts for these funds and services will be developed in anticipation of the awarding of the grant. The administrative component of the block grant is used to support Planning Council activities and perform administrative and accountability functions, such as the development of prevalence estimates and mechanisms for monitoring program accountability and expenditures of block grant funds.

TABLE ONE

FFY'07 PROJECTED BLOCK GRANT SPENDING PLAN (Page 134)

Program Code	Description	FFY 07 %	Projected FFY 07 Funding
3007	Program Management	1.06%	$ 86,077.00
	Subtotal Administration	1.06%	$ 86,077.00
3039	Homeless Support Services	0.37%	$ 29,698.00
3034	Clubhouse Services	6.75%	$ 548,988.00
3049	Adult Residential Services	19.00%	$ 1,545,304.00
3048	Respite Care Services	9.92%	$ 806,320.00
3036	Services for Education and Employment	8.20%	$ 666,976.00
3056	Individual Support	0.78%	$ 63,609.00
3059	Community Rehabilitative Support	12.62%	$ 1,026,485.00
	Subtotal Adult Services	57.65%	$ 4,687,380.00
3064	Contracted Child/Adolescent OutPatient Services	0.00%	$ -
3065	Community & School Support	15.49%	$ 1,259,563.00
3066	Individual and Family Flexible Support	15.11%	$ 1,228,349.00
3068	Day Services	0.56%	$ 45,423.00
3078	Child/Adolescent Respite Care	0.49%	$ 39,500.00
3079	Child/Adolescent Residential Service	0.51%	$ 41,651.00
	Subtotal Children's Services	32.15%	$ 2,614,486.00
3015	Client & Community Empowerment	6.01%	$ 488,417.00
3023	Research	1.76%	$ 143,292.00
3027	Adult Forensic Court Services	1.37%	$ 111,512.00
	Subtotal Mixed Services	9.14%	$ 743,221.00
	Total Services	100.00%	$ 8,131,164.00

TABLE TWO

FFY'07 BLOCK GRANT FUNDS SPENDING PLAN BY AREA (Page 135)

TABLE TWO
(continued)

STATE MENTAL HEALTH PLANNING COUNCIL LETTER